DHS COVID-19 QUARANTINE AND ISOLATION (QI) MEDICAL SHELTERS POLICY AND PROCEDURE

Subject: **Medical Documentation**	Original Issue Date: N/A	Policy 08
		Effective Date: 2/17/21
Departments Consulted: Housing for Health, Pomona QI Clinical	Reviewed & Approved by: Housing for Health Medical Director, QI Medical Shelter Medical Director	

PURPOSE: To ensure that medical documentation regarding client admission, ongoing care, medication administration/reconciliation, sentinel events, and discharge are accurate, complete, timely. To ensure that medical information is maintained in compliance with Health Insurance Portability and Accountability Act (HIPAA) rules and regulations.

Medical documentation at the QI Medical Shelters occurs on paper and includes:

- Individual client medical charts
- Vital signs logs
- Client incident logs
- Stock medication log
- Controlled substances log

POLICY:

MEDICAL CHARTS

- All clinical staff will record client information in the medical chart in a comprehensive, accurate, and timely way.
- All clinical staff will record client information in the medical chart as soon as possible after the relevant task, event, or observation and ensure that the documentation reflects the actual time of the event and chronology of events.
- All clinical staff will record client information in the medical chart in a legible manner using black or blue ink and ensure that all charting is date and time stamped.
- All clinical staff will record client information in the medical record per standard documentation guidelines and print/sign their names at the end of each entry.
- All documentation will occur on pages where the name, date of birth, and room number are clearly delineated. In the event two people with similar names are at the QI site at the same time, mother's maiden name will also be documented on each page of the medical chart.
- All clinical staff will record in the medical chart using approved abbreviations.
- All clinical staff will ensure that medical charts and other sensitive client information are managed such that only relevant personnel critical to the care of the client have visibility and access to protected information.
- No clinical staff will erase or otherwise destroy documentation once charted in the medical record.

PROCEDURE:

Provider Procedures:

- Providers will write a comprehensive, legible, and accurate admission note that includes the history of present illness, past medical history, medications, allergies, review of systems,

physical exam, and assessment and plan of care within four (4) hours of provider evaluation or client admission.

- Providers will write admission orders within one hour of client admission.
- Providers will write progress notes within four hours of client visit, observation, or task and document the rationale behind any change in orders. In general, Acuity 1 patients with active issues should have daily provider progress notes in the medical chart. As providers are not always on site overnight and on the weekends, summary notes can be written when the provider is next on site. Nurse can seek email verification of verbal order from 24/7 provider on call at Pomona QI shelter.
- All provider orders should be written in the medical chart when the provider is on site. Overnights and on weekends, when providers are not available, the RN can take a verbal order from the clinician and document as such in the client medical chart. This order should be cosigned by the provider when he/she is next on site.
- Providers will write discharge notes that include the course of care, prescription orders, medication changes, and client instructions prior to client discharge from the QI site.
- Providers will transcribe or print any electronic prescription requests in chart for nurses to place in the Medication Administration Record (MAR.)

Registered Nurse (RN) Procedures:

- RNs will document findings on presentation to the QI site within four hours of admission.
- RNs will document analysis of assessment findings and the plan of care within four hours of admission.
- RNs will document administration of medications, treatments, and comprehensive nursing interventions as soon as possible after completion of the task.
- Per acuity level:
    - Acuity 1: RNs should chart one progress note per shift
    - Acuity 2: RNs should chart one progress note per day
    - Acuity 3: RNs should chart one progress note every 48 hours
    - Acuity 4: RNs should chart progress notes as events occur
- RNs will document client/family education provided and responses to teaching as applicable.
- RNs will document abnormal findings or relevant incidents as reported by a COVID-Tech and document appropriate response and follow up
- RNs will maintain accurate medication administration records as well as ensure that stock medications are correctly inventoried and “signed out.”

Licensed Vocational Nurse (LVN) Procedures:

- LVNs will write vital signs down on vital signs log at a frequency directed by team RN. In general, Acuity 1 clients should have vital signs checked at least once per shift. Acuity 2 clients should have vital signs checked at least once per day. Acuity 3clients should have vital signs checked every 48 hours. Acuity 4 clients should have vitals checked only as requested by RN or provider. Abnormal findings will be reported to the RN immediately.
- LVNs will document client incidents on incident log as directed. Critical or time-sensitive incidents should be reported to the RN immediately.

- LVNs will document information collected through client interview in client medical chart, as necessary.
- LVNs will document observations regarding client condition in client medical chart, as necessary
- LVNs will document data collected from techniques of physical examination in client medical chart, as necessary.
- LVNs will document client reactions to medications and treatments as observed and reported by client in client medical chart, as necessary.
- LVNs will document any administration of approved medications, treatments, nursing interventions in which they participated, client instructions, and/or demonstration of nursing procedures in client medical chart, as necessary.

Certified Medical Assistant (CMA) Procedures:

- CMAs will document basic medical information in accordance with their duty statements, including: client's medical history, vital signs, or symptoms.
- CMAs will document any abnormal findings and report verbally to the RN.

Emergency Medical Technicians (EMT) Procedures:

- EMTs will document basic medical information in accordance with their duty statements, including: client's medical history, vital signs, or symptoms.
- EMTs will document any abnormal findings and report verbally to the RN.

REFERENCE:

- LAC USC Nursing Services Policy #402: "Documentation"
- LAC USC Medical Center Policies #403 and 412
- Ambulatory Care Network Policy # ACN CD-01.018: "Documentation: Comprehensive Health Assessment"
- California Code of Nursing; Title 22: Section 70527d
- Joint Commission Standards